MARYLAND
DUALS CARE DELIVERY WORKGROUP

APRIL 4, 2016 | 1:00-4:00 PM

RECAP

- At the first workgroup meeting, we provided context to the needs of the dual eligible population in Maryland
- In March, DHMH collected input from work group members and other stakeholders on needs and potential solutions for dual eligibles
- DHMH and HSCRC – and consultants – have met several times to consider approaches for dual eligibles that will be compatible with the evolving All-Payer Model. These efforts will continue.

AGENDA

- Utilization Data on Full Dual Eligibles
- Review of Stakeholder Survey Feedback
- Discussion of Emerging All-Payer Model Efforts
- Straw Models
- Discussion
- Next Steps
- Public Comment

MEDICARE AND MEDICAID UTILIZATION PATTERNS OF NON-DD FULL DUALS, CY 2012

Population Characteristics and Service Use of Non-DD, Medicare FFS Full Dual Eligibles, CY12

Aged			✓	✓	✓	✓
Disabled or Physically Impaired	✓	✓			✓	✓
Mental Illness		✓		✓		✓
n	**12,555**	**16,591**	**18,213**	**4,678**	**8,679**	**9,141**
Percent with 1+ Inpatient Stays	19.8%	26.2%	16.9%	27.3%	44.0%	44.8%
Average Number of Stays Per User	2.1	2.3	1.6	1.7	2.0	2.1
Percent with 1+ SNF Stays	3.6%	7.1%	3.2%	6.5%	34.5%	37.4%
Average Number of Days Per User	23.8	28.8	11.9	13.4	24.1	32.1
Percent Medicaid LTSS	9.5%	13.8%	18.3%	40.1%	73.4%	87.5%
Percent Nursing Facility	3.7%	8.1%	0.0%	0.0%	63.3%	79.1%
Percent HCBS (1915c or State Plan)	6.1%	6.3%	18.3%	40.1%	12.1%	11.5%

Characteristic	Definition
Aged	65 years old or older
Disabled or Physically Impaired	Mobility Impairments, Cerebral Palsy, Muscular Dystrophy, Spina Bifida, Spinal Cord Injury *or*
	Medicaid NF LoC via NF stay or 1915(c) enrollment *or*
	Original Medicare eligibility due to disability/ESRD
Mental Illness	Depression, Anxiety Disorders, Bipolar Disorder, Conduct Disorders and Hyperkinetic Syndrome, Personality Disorders, Schizophrenia and Other Psychotic Disorders

MEDICAID SETTING AND COSTS OF NON-DD FULL DUALS

Medicaid Setting of Non-DD Full Dual Eligibles, FY15 (Not Mutually Exclusive)

Setting	Full Dual Participants	Medicaid PMPY
Chronic Health Home*	1,814	$32,717
1915(c)	7,956	$34,444
State-Plan HCBS (CFC & CPAS)	6,284	$35,061
Nursing Facility	18,543	$53,092

* Cost figure is from health home evaluation study for CY 2014. The PMPY includes non-duals as well.

Issues Concerning Ways Duals Receive Care

Fragmentation/Lack of coordination

Lack of coordination between acute, primary, and long term care is one of the biggest challenges.

Duplicative services

Due to the different benefits and reimbursement rules in fee-for-service (FFS) Medicare and Medicaid, providers have an incentive to deliver [increased] care and services in a manner that maximizes reimbursement.

Inadequate access to primary care

[There is an] over reliance on hospital based services rather than primary care.

Issues Concerning Ways Duals Receive Care

Care is not person centered and there is little consideration of social, financial, and behavioral barriers.

The delivery of care today is overly medicalized and there is limited consideration non-clinical factors that not only affect the health status of the individual but also act as barriers to treatment adherence and limit treatment outcomes.

Currently, healthcare services are delivered according to the convenience and culture of the system, not the convenience and culture of the patient.

Health providers commonly make assumptions of self-reliance, cognitive competencies and commitment to compliance that can be very unrealistic.

DUALS CARE DELIVERY WORKGROUP SURVEY RESPONSES

How should these issues be addressed?

Increased case management through use of care managers

Care coordination done by care managers allows for the integration of social issues which can then be factored into the medical care that is provided.

Primary Care

All duals should have a primary care provider. . . . Primary care capacity should be expanded through use of nurse practitioners, physician assistants, etc.

Each non-institutionalized dual should be assigned to a PCP or medical home.

Greater emphasis on person-centered care

Care should begin with a health risk assessment that focuses on the goals and needs of the patient. A care plan should then be developed that is centered on those goals and needs.

Integration of Medicare and Medicaid under one plan

Upon selection of a D-SNP, the beneficiary is automatically enrolled in Medicaid plan from the same company.

What outcomes will a successful duals care delivery model achieve?

Better patient health outcomes

The initial focus should be on improving health outcomes, with costs savings from improved health and avoided hospitalization and nursing facility stays being achieved in the long-term.

Patient centered care

Person-centered plan of care will facilitate patient trust in any new system and patients will "own" their health.

Better end-of-life care focused on patient goals

Increase use of advanced directives to halt unwanted and expensive end-of-life care.
Increase hospice utilization rather than hospital-based care.

Use of quality metrics

A uniform set of metrics by which to evaluate clinical outcomes.

How can a duals care delivery model accomplish care coordination across Medicare and Medicaid?

Define care coordination as a state. This effort was started with the Community Health Worker Report that was released this year.

The Program of All-inclusive Care for the Elderly (PACE) is a successful model of integrated care management that allows the provider to allocate resources according to individual need rather than the dictates of billing codes and arbitrary benefit limitations.

Any model needs a single point of accountability for management, coordination, and delivery, including LTSS.

HSCRC or another state entity must provide care management services for the FFS duals.

How can a duals care delivery model help reduce the total cost of care?

Active case management and care coordination in primary care

- *Provide reimbursement to PCPs for care coordination activities*
- *Development of risk scores that include social determinants of health and disease states, mental health diagnoses, etc. so . . . providers can allocate resources to [individuals] appropriately*
- *If we can get to a place where payment is sufficient to cover total cost of care for primary care teams while allowing them the flexibility to be innovative in how they manage their patients, we could lower costs and improve outcomes.*

How can a duals care delivery model help reduce the total cost of care?

Change reimbursement system from volume-based (FFS system) to value-based (at-risk system)

- *Under a fee-for-service system, not only do providers receive no revenue to cover the cost of time spent on interventions that may produce improved outcomes but those interventions may reduce future revenue by eliminating the need for future billable services. Under an at-risk system, the provider has incentive to invest time in interventions that produce more cost efficient care with better long-term outcomes.*

DUALS CARE DELIVERY WORKGROUP SURVEY RESPONSES

What providers would be able to handle risk arrangements?

Accountable Care Organizations (ACOs)

Larger Long Term Care facilities

A specialty Behavioral Health ACO

Behavioral health providers are interested [in entering risk sharing]. A specialty BH ACO could enter into a risk arrangement on behalf of its members.

Providers in a shared geographic area

Consider focusing on individual providers and all providers in a geographic area with high numbers of dual eligibles and/or poor population health, high cost, ER, in-patient care, etc.

Rather than applying risk to individual providers, apply risk arrangements tied to quality outcomes across the care spectrum to encourage to work together to focus on care outcomes

Health Plans

How can a delivery model promote utilization of community-based services?

Any model that is developed should leverage existing community-based resources before considering new ones.

There may be a need for increased services not traditionally covered by Medicare/Medicaid.

Before discussing how utilization of community-based services can be promoted, we need a discussion on network adequacy.

> *Some sort of supply/demand analysis needs to occur to understand where there are gaps in community-based providers… Promoting the utilization of community-based services hinges on a delivery model with a broad network of providers that provide care in all settings.*

A capitated duals care delivery model will promote utilization of community based services as lower cost community services could be paid for instead of expensive medical services.

What other programs and initiatives should be leveraged in developing a model?

A key factor that must be taken into account in developing a duals care delivery model in the interchange between this model and the HSCRC Waiver. The two must be integrated and this model must be a key component in the design of care coordination efforts by the HSCRC, including the development of the ICN.

Look at care coordination models such as PACE, Person Centered Medical Homes (PCMH), and chronic care medical homes.

Community programs, such as Community Aging in Place, Advancing Better Living for Elders (CAPABLE), which combines home modifications with occupational therapist and nurse practitioner home visits to help people with one or more activities of daily living (ADL) stay in their home

DUALS CARE DELIVERY WORKGROUP SURVEY RESPONSES

What else needs to be considered?

Any program should have meaningful consumer engagement at the system level baked into it from the outset.

Alignment across payer sources, without necessarily integrating payments, is essential. This workgroup should identify areas where Medicare and Medicaid policy conflict in terms of policies or covered services.

It is important to note that Duals are not a population but a varied group of individuals.

A simple, consistent statewide approach [is needed] so providers can understand and adapt.

ELEMENTS APPLICABLE TO ALL MODELS

- Guiding Principles
- Programmatic Continuity
- Information Infrastructure

GUIDING PRINCIPLES

In designing new care delivery models for dual eligibles …

For Beneficiaries

- Reach for whole-person care integration
  - Physical/Acute
  - Behavioral
  - LTSS
  - Social
- Follow a person-centered care model
- Aim for improved
  - Patient experience
  - Health outcomes
  - Quality of life
  - Access to care

For Providers

- Promote value-based payment to reward providers who help reach program goals
- Support providers via
  - Health information exchange
  - Analytics tools
  - Administrative simplicity
- Enable physicians to qualify for APMs bonus under MACRA*

For the State

- Address total cost of care for both Medicaid and Medicare
- Make the program interoperable with the All-Payer Model

Cross Cutting

- Promote utilization of community-based resources

* Alternative Payment Models bonus of 5% for physicians in Medicare fee-for-service, starting in 2019

PROGRAMMATIC CONTINUITY*

Maryland's existing waivers and programs will be integrated into the final design for dual eligibles:

- Home and Community-Based Options Waiver Program
- Community First Choice Program
- Community Personal Assistance Services
- Money Follows the Person (MFP)
- Traumatic Brain Injury (TBI) Waiver
- Chronic Health Homes

* Programs are further detailed in Appendix A

INFORMATION INFRASTRUCTURE

Information/Data resources to be tapped for any model chosen:

- CRISP's Integrated Care Network / Electronic Notification System (ENS) – All Maryland Acute Care hospitals real time admission, discharge, transfer (ADT) messaging; expanding to physician offices and nursing homes
- Hilltop Institute – Modeling; Risk stratification to identify vulnerable populations
- LTSS Maryland – InterRAI-HC Information System, risk assessment
- Minimum Data Set (MDS) – NF resident assessment Resource Utilization Groups (RUGs)
- Home Health – Outcome Assessment and Information Set (OASIS)
- CMS Chronic Conditions Data Warehouse (CCW) – Medicare claims data specific to beneficiaries with chronic conditions
- Medicaid Management Information System (MMIS)

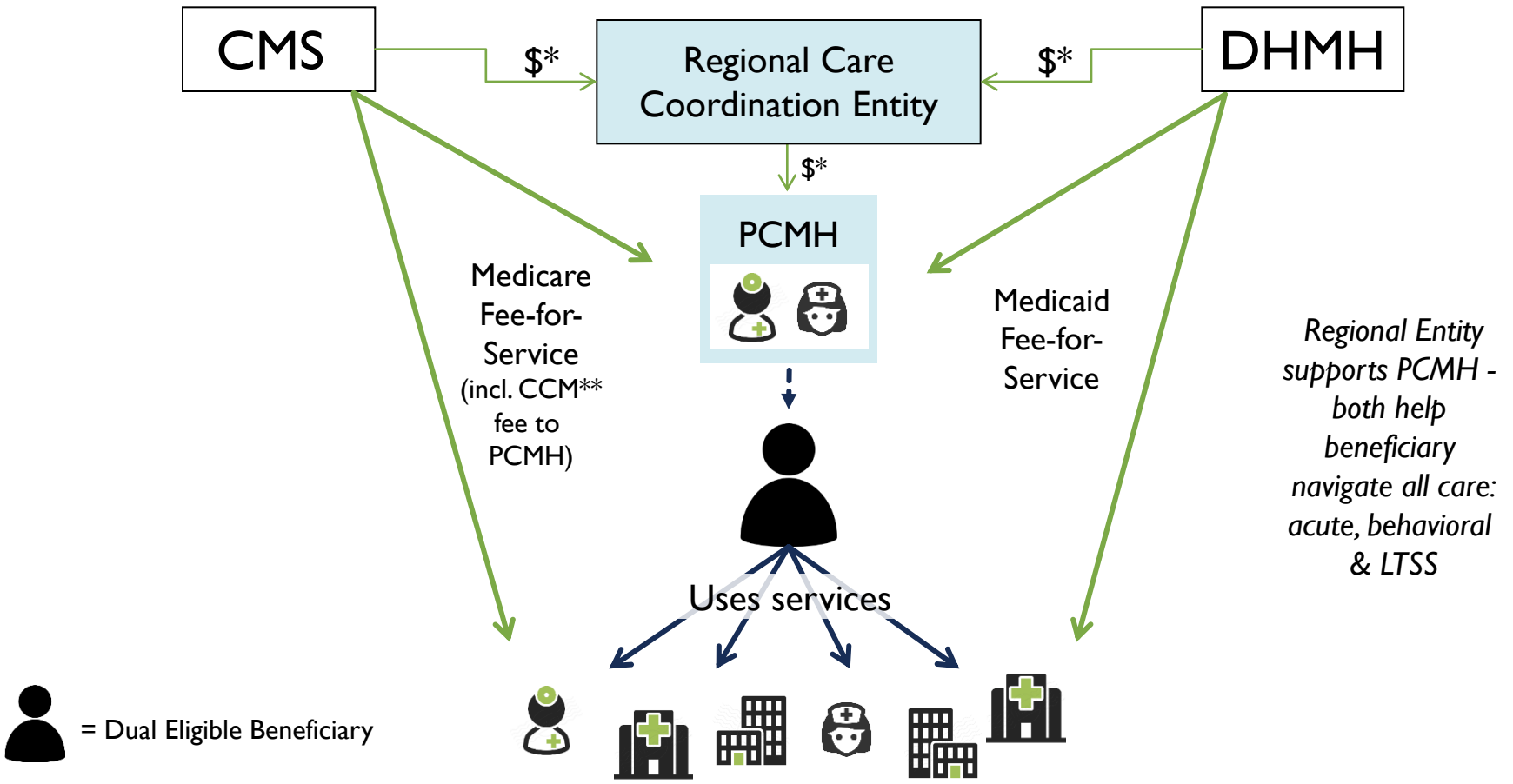
UPDATE ON EMERGING ALL-PAYER MODEL EFFORTS

- Donna Kinzer, HSCRC

3 STRAW MODELS

- Managed Fee-for-Service for Dual Eligibles
- Dual Eligibles Accountable Care Organizations
- Capitated Health Plans for Both Medicare & Medicaid

MANAGED FEE-FOR-SERVICE FOR DUALS



* $PMPM for care management

**CCM = Chronic Care Management: "At least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month" CMS code 99490

MANAGED FEE-FOR-SERVICE FOR DUALS

Beneficiaries to Be Covered by MFFS for Duals

- All full-benefit duals not with I/DD, except
  - Medicare Advantage plan enrollees
  - PACE enrollees
  - Dual eligibles in Medicare ACOs [Shared Savings Program or Next Generation]
- Beneficiaries align with PCMH, free to use any Medicare/Medicaid providers

Entities and Functions

- DHMH, with CMS aid, contracts with Regional Care Coordination Entities, each serving as care management hub
  - Contractors could be entities organized by providers in communities, health plans furnishing only care management services, or private firms
  - Regional entity's scope of work entails …
    - Assistance to PCMH and direct to beneficiaries in navigating all health services
    - Intensive case management for beneficiaries deemed high need or at risk of high cost
    - Pre-authorization of services judged overused or high cost and uncertain efficacy

MANAGED FEE-FOR-SERVICE FOR DUALS

Entities and Functions (continued)

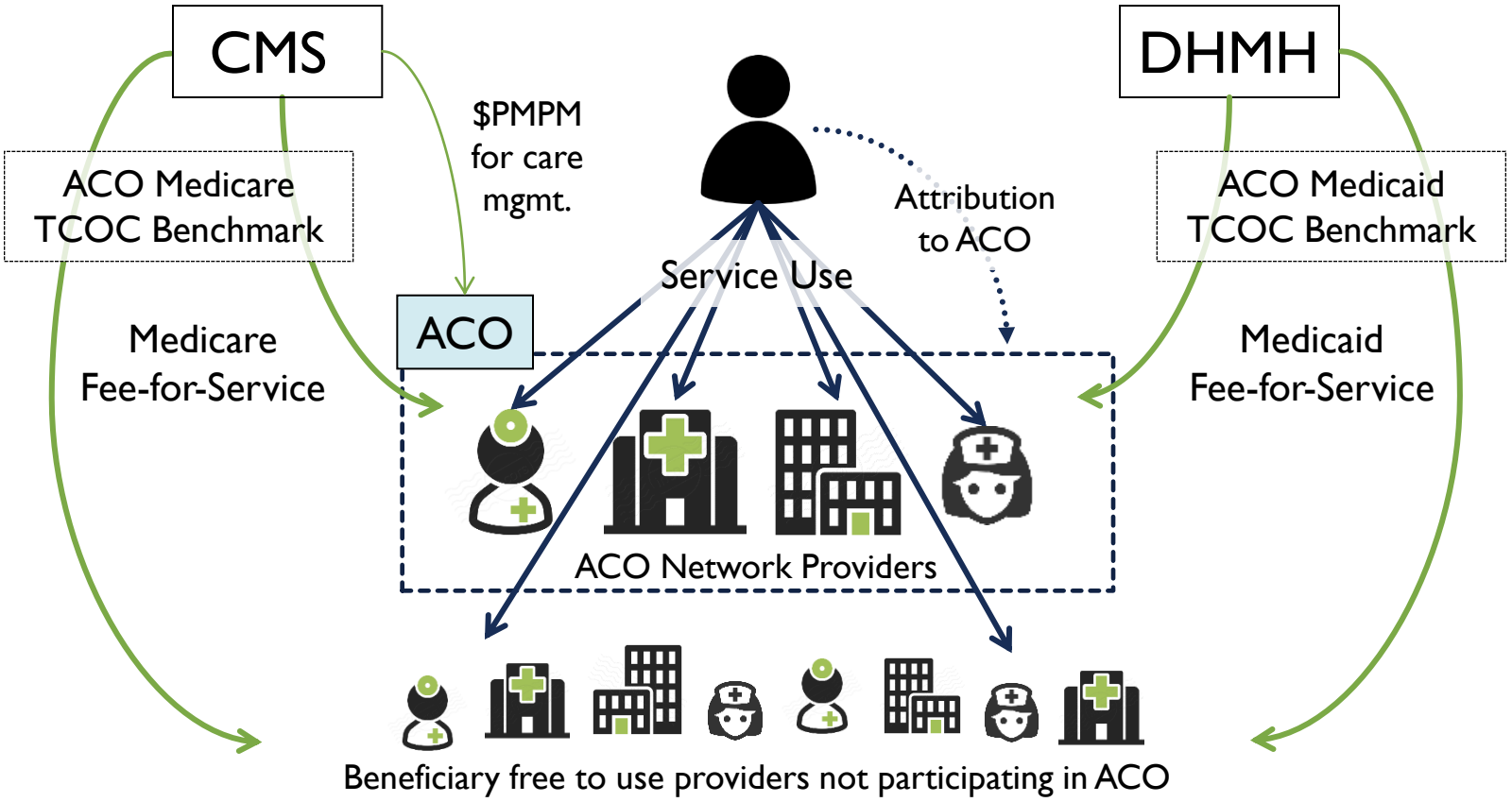
- Primary Care Medical Home is chosen by each beneficiary and assumes responsibility for delivering primary care and coordinating use of other services
  - PCMH may be based in a nursing facility if beneficiary is in resident in NF
  - PCMH may be a specialty provider if beneficiary has chronic condition
  - Expectation that PCMHs will engage in Medicare Chronic Care Management for eligible beneficiaries, Transitional Care, other pay-for-outcome (P4O) efforts

MANAGED FEE-FOR-SERVICE FOR DUALS

Financial Provisions

- All provider payment is regular Medicare/Medicaid fee-for-service
- Regional Entity gets a PMPM care management fee, part going to PCMH
- CMS & DHMH set a joint Medicare-Medicaid total cost of care (TCOC) benchmark, against which Regional Entity performance is measured
  - Benchmark is region-specific and risk-adjusted based on population disease mix
- Agencies determine end-of-year surplus/deficit vs. benchmark
- Regional entities may be awarded bonuses for achieving surplus
  - Subject to a minimum savings rate to account for random chance
  - Possibility for PCMHs that contributed to savings to share in bonus awards

DUALS ACO


CMS
DHMH
$PMPM for care mgmt.
ACO Medicare TCOC Benchmark
ACO Medicaid TCOC Benchmark
Attribution to ACO
Service Use
ACO
Medicare Fee-for-Service
Medicaid Fee-for-Service
ACO Network Providers
Beneficiary free to use providers not participating in ACO

DUALS ACO

Qualifying Entities

- A Duals ACO (D-ACO) is a provider-sponsored network that covers part or all of Maryland and has resources to …
  - Deliver PCMH services to attributed dual eligibles
  - Coordinate care for dual eligibles spanning acute care, behavioral care & LTSS as well as linking to social services
    - Duals ACO network must include all types of providers
  - Receive and analyze data on attributed beneficiaries
  - Report to providers and DHMH/CMS on activities and outcomes of care
    - Interconnection via CRISP required to enable both of above
  - Eventually, bear at least modest financial risk for beneficiaries' total cost of care
- Existing Medicare ACOs (MSSP or NextGen) may become D-ACOs by augmenting capabilities; must apply and gain D-ACO designation
  - Application goes to DHMH, secondary review by CMS
- Entities not already Medicare ACOs may apply to become D-ACOs
  - Application evaluated jointly by DHMH and CMS
  - ACO's option to seek simultaneous approval as Medicare-only ACO

D-ACOs may define own service areas as long as those areas are contiguous and non-discriminatory. More than one D-ACO is allowed in any given area.

DUALS ACO

Beneficiaries Qualifying for Duals ACOs

- All full-benefit duals not with I/DD, except
  - PACE enrollees
  - Medicare Advantage plan enrollees
  - Dual eligibles already in Medicare FFS ACOs that do not become D-ACOs
  - Dual eligibles residing in areas not served by D-ACOs

Linking Beneficiaries to Duals ACOs

- If a beneficiary was already attributed by CMS to a Medicare ACO that becomes a D-ACO, that attribution holds unless the beneficiary affirmatively chooses another ACO
- All other qualifying beneficiaries are mandated to become enrolled in a D- ACO for Medicaid purposes, and once so linked, are attributed to the same ACO by Medicare
  - Beneficiary may choose a preferred D-ACO
  - If none chosen, DHMH will assign one based on criteria similar to those used to assign Medicaid MCOs to non-choosers

Assumes CMS will allow mandated enrollment by Medicaid if only one ACO is available, because the beneficiary may still use any providers in or out of network

DUALS ACO

Funding for D-ACO Care Management

- D-ACO receives an up-front care management fee (PMPM) from CMS to help cover administrative costs of care coordination/case management
  - CM fee isn't "free" but is netted out of TCOC savings calculation (below)

Payment for Health Care Services

- CMS and DHMH (or their administrative contractors) pay Medicare and Medicaid claims in the usual FFS fashion at established fee rates

D-ACO Incentive Arrangement

- Upon beneficiary's attribution to a D-ACO, CMS and DHMH each allocate a TCOC PMPM benchmark amount to a pool associated with that D-ACO
  - Benchmark amounts are set separately for Medicare and Medicaid; pools are tallied separately *(Future consideration: Blend pools together up front)*
  - Benchmark amounts are risk-adjusted; both CMS and DHMH use an identical (unified) risk adjustment formula
- Initially, D-ACOs are not at risk for net deficits; this will change over time
  - Downside risk will be phased in starting Year 3
  - Risk/Reward formula will be skewed more to incentive bonus than to penalty

DUALS ACO

D-ACO Incentive Arrangement (continued)

- At end of performance year, Medicare and Medicaid payments each are summed and compared to amounts allocated to benchmark pools
- If both the D-ACO's Medicare and Medicaid pools are in deficit, no award
- If either pool (Medicare or Medicaid) is in deficit, that deficit is subtracted from the surplus in the other pool to determine potential for bonus award
- Aggregate of care management fees received by D-ACO is subtracted from net surplus to determine basis for potential award to D-ACO
- D-ACO's quality score must surpass set threshold for award eligibility
  - Quality measures TBD but will be unified and suitable for dual eligibles (See Appendix for a potential set)
- D-ACO will receive a savings/quality award of 50% of net surplus amount
- D-ACO is expected to distribute a meaningful portion of any award to network providers who it deems contributed to positive performance
  - D-ACO may retain some of award to offset operational expenses not otherwise covered by the CM fee

CAPITATED HEALTH PLANS FOR DUALS

CMS

CMS Administrative Alignment Partnership

DHMH

One Plan Sponsor

MA D-SNP

Capitation Payment for:
Medicare Part C and Part D
Physician Services
Inpatient Hospital Services
Outpatient Pharmacy

Medicaid D-MCO

Capitation Payment for:
Nursing Facility Services
HCBS Services
Outpatient Services
Personal Care Services

Hospital Contracts: HSCRC Rate, Plus Upside/Downside Risk or Sub-capitation

ACOs under Contract: Capitation or Fee-for-Service Rates Plus Upside/Downside Risk

Health Home Contracts: PMPM for Case Management and Physician Services

DUALS CAPITATED HEALTH PLANS

Basic Design

- Capitated program including Medicaid and Medicare services for duals through integration with Medicare Advantage Duals SNP (MA D-SNP)

Entities

- Health plan sponsors that secure 2 kinds of contracts
  - Medicare Advantage Duals Special Needs Plan (MA D-SNP)
  - Medicaid MCO for Dual Eligibles (D-MCO)
- DHMH requires D-MCO sponsor to have MA D-SNP contract
  - Initial program implementation could include current Medicaid Health Choice MCOs with D-SNP contracts
  - DHMH can choose to hold selection process for additional D-MCOs
- Established care delivery entities and coordinators continue to function, though are contracted to health plans
  - Medicaid and Medicare FFS providers
  - Medicaid Health Homes

DUALS CAPITATED HEALTH PLANS

Eligibility, Enrollment and Assignment

- Eligible beneficiaries include all full duals except I/DD
  - Includes those duals deemed nursing facility level of care, as well as those whose dual eligibility is based on a qualifying condition and/or disability (behavioral health needs, etc.)
- Beneficiary is mandated to enroll in D-MCO plan, is passively enrolled or enrolls voluntarily in same sponsor's companion MA D-SNP plan
  - Full duals currently in MA D-SNP plans will automatically be in new program
  - Newly eligible duals will choose or be auto-assigned into one of Duals plans
  - Medicare enrollment mandate is unlawful; greater odds of MA D-SNP take-up if CMS provides for **passive enrollment with opt-out** (using demo authority)
  - If beneficiary opts out for Medicare coverage, program operates as Medicaid-only capitation to MCO
    - To aid integration, using demo authority, DHMH can work with CMS to develop information sharing agreements between Medicaid D-MCOs and Medicare FFS providers

DUALS CAPITATED HEALTH PLANS

Administrative Alignment

- Beneficiary receives one ID card, unified set of disclosure documents
- All care coordinated by the one plan sponsor
- Seamless conversion from Medicaid MCO when Medicaid-only beneficiary gains Medicare coverage
- Member complaint, grievance and appeal processes are unified to fullest possible extent
- D-MCOs must maintain separation of provider payments for Medicare and Medicaid but will produce combined reports
  - Display combined utilization and payments for services for which Medicare is primary payer and Medicaid secondary payer
  - Display utilization and payments for services for which Medicaid is sole payer
  - Aggregate data to reveal "blended" utilization and spending

DUALS CAPITATED HEALTH PLANS

Care Model

- Interdisciplinary Care Team (ICT) can be utilized to integrate and coordinate care between Medicare and Medicaid services and ensure continuity of care between existing programs for duals and D-MCO plan
  - ICT is a requirement in the SNP Model of Care and was a requirement for MCOs participating in CMS duals demonstration
    - ICT brings together those individuals deemed a part of beneficiary's "care team" to discuss health status, changes to treatment plan, etc. May include but not limited to: beneficiary, caregiver, care manager, PCP, specialist, behavioral health, home health nurse etc.
      - Duals demo ICT was very prescriptive requiring every individual in the demo to have an ICT and requiring specific provider types be on the ICT
      - Maryland has opportunity to define ICT as it sees fit under demo authority, and to require initial health assessment be completed to determine participants in beneficiary's ICT
  - Demo authority could allow state to require Medicare FFS PCPs to participate in ICTs if/when beneficiary opts out of MA D-SNP

DUALS CAPITATED HEALTH PLANS

Care Model (continued)

- Potential widened use of Health Home model for care coordination and navigation through services
  - Current Health Homes will serve as behavioral health integration for duals having serious mental health/substance abuse needs
  - Potential additional health homes created for those duals in NFs or HCBS
  - Health homes and the D-MCOs will share data seamlessly and monitor their members through existing data connections with CRISP

Quality Measurement

- DHMH works with CMS to harmonize D-MCO plan quality rating with factors used in Medicare Advantage star ratings (See Appendix for a potential set)

DUALS CAPITATED HEALTH PLANS

Payment

- Health plan gets separate Medicaid and Medicare capitation payments
  - Plan does not blend funds into single pool
  - Using demo authority, plan can submit blended claims to CMS to show Medicare and Medicaid services used
- MA D-SNP plans must bid on MA at a low enough level to ensure that member premium is $0
- After Performance Year 1, both Medicare and Medicaid capitations vary by plan quality performance
- MA D-SNP plans may process an integrated set of claims rather than segregate Medicare from Medicaid payments
- D-MCOs pay Health Homes a PMPM fee for care coordination/navigation for those beneficiaries who participate in HHs

QUESTIONS FOR FURTHER STUDY

- How should regions be defined?
- For ACOs:
  - What is the best reward/risk formula to incentivize appropriate behavior?
  - What type of attribution makes sense, and how does TCOC work into the attribution discussion?
- Which model, if any, will qualify under MACRA as alternative payment models (APMs) so physicians can get the extra 5% from Medicare starting in 2019?
- Which programmatic populations should be carved out?
- How should quality be measured, and what are the benchmarks?

NEXT STEPS

- Refine preferred model, or combination of models, and assess feasibility
- Explore federal waivers required for implementation
- Introduce quality measurement options

Next Work Group meeting:
May 2, 2016, 1:00-4:00 pm

APPENDIX A. PROGRAMMATIC CONTINUITY

Maryland's existing waivers and programs will be integrated within the final design for dual eligibles:

- Home and Community-Based Options Waiver Program - Provides an array of home and community-based services that assist Medicaid beneficiaries to live and remain in the community of their choice and allows for self-direction of services. Individuals must require a nursing facility level of care based on a uniform medical assessment. Merges the New Directions and Community Pathways Waivers
- Community First Choice Program - Provides community services and supports to enable older adults and people with disabilities to live in their own homes. Individuals must require an institutional level of care based on a uniform medical assessment
- Community Personal Assistance Services - Provides community services and supports to enable older adults and people with disabilities to live in their own homes. Individuals must live in the community, need help with activities of daily living in their homes, and meet the program's medical level of care.
- Money Follows the Person (MFP) - Participants access services through three of Maryland's existing home and community-based services (HCBS) waiver programs and the Community First Choice state plan program
- Traumatic Brain Injury (TBI) Waiver - Serves adults with traumatic brain injuries to MFP participants that are transitioning from the three State owned and operated nursing facilities or Commission on Accreditation of Rehabilitation Facilities (CARF) accredited chronic hospitals.
- Chronic Health Homes - Targets populations with behavioral health needs – diagnoses of serious persistent mental illness (SPMI), opioid substance use disorders (determined to be at risk for a second chronic condition), or children with serious emotional disturbance (SED) – who are at high risk for additional chronic conditions, offering them enhanced care management services from providers with whom they regularly receive care. Participants must be enrolled to receive the appropriate psychiatric rehabilitation program (PRP), mobile treatment, or opioid treatment program (OTP) services from a Health Home provider in order to qualify for Health Home.

APPENDIX A. (CONT'D.) PROGRAMS AND SERVICES

Services and Programs	Personal Assistance	Personal Emergency Response System	Case Management/ Transition Planning	Technology	Environmental Assessments	Accessibility Adaptations	Home Delivered Meals	Consumer Training	Transition Services	Assisted Living	Medical Day Care	Senior Center Plus	Dietician and Nutritional Services	Behavioral Consultation	Nursing Care/ Monitoring	Also includes:
Program for All-Inclusive Care for the Elderly (PACE)	x	x	x	x	x	x	x	x	x	x	x		x	x	x	Primary and Specialty Care, Hospital and Skilled Facility coverage, Rehabilitation, Social Work Services, Transportation, Recreation, Meals, In-Home Care, Physician Care and Supervision, Dialysis, Prescriptions
Home and Community-Based Options Waiver	x	x	x	x	x	x	x	x		x	x	x	x	x		Family Training
Community Personal Assistance Services	x	x	x												x	
Community First Choice	x	x	x	x	x	x	x	x	x							
Chronic Health Home									x							Family and Individual Support Services, Comprehensive Care Management, Care Coordination, Referral to Community and Social Supports, Health Promotion
Money Follows the Person									x							
Traumatic Brain Injury (TBI) Waiver											x					Day Habilitation, Environmental Modifications, Supported Employment, Residential Rehabilitation

APPENDIX B. POTENTIAL QUALITY MEASURES

	Quality of Care Measures – Dual Eligibles (Preliminary List)	
NQF #	**Measure Title**	**Measure Steward**
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*	NCQA
0006	CAHPS Health Plan v 4.0 – Adult questionnaire	AHRQ
0018	Controlling High Blood Pressure*	NCQA
0022	Use of High-risk Medications in the Elderly	NCQA
0032	Cervical Cancer Screening	NCQA
0101	Falls: Screening, risk-Assessment, and Plan of Care to Prevent Future Falls	NCQA
0104	Adult Major Depression Disorder (MDD); Suicide Risk Assessment	American Medical Association – Physician Consortium for Performance Improvement
0105	Antidepressant Medication Management*	NCQA
0201	Pressure Ulcer Prevalence (Hospital Acquired)	NCQA
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan*	CMS
0421	Adult Weight Screening and Follow-up	CMS
0553	Care for Older Adults (COA) – Medication Review	NCQA
0554	Medication Reconciliation Post-Discharge	NCQA
0576	Follow-Up After Hospitalization for Mental Illness	NCQA
0648	Timely Transmission of Transition record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	American Medical Association – Physician Consortium for Performance Improvement
1768	Plan All-Cause Readmissions*	NCQA
2380	Rehospitalization During the First 30 Days of Home Health	CMS
2456	Medication Reconciliation Number of Unintentional Medication Discrepancies per Patient	Brigham and Women's Hospital
2502	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)	CMS
2505	Emergency Department Use Without Hospital Readmission During the First 30 Days of Home Health	CMS
2510	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	CMS
2512	All-Cause Unplanned Readmission Measure for 30-Days Post Discharge from Long-Term Care Hospitals (LTCHs)	CMS
2597	Substance Use Screening and Intervention Composite	American Society of Addiction Medicine
2599	Alcohol Screening and Follow-Up for People with Serious Mental Illness	NCQA
2600	Tobacco Use Screening and Follow-Up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NCQA
2601	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness	NCQA
2602	Controlling High Blood Pressure for People with Serious Mental Illness	NCQA
2603	Diabetes Care for People with Serious Mental Illness Hemoglobin A1c (HbA1c) Testing	NCQA
2604	Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy	NCQA
2605	Follow-Up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	NCQA
2606	Diabetes Care for People Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)	NCQA
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA
2608	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA
2609	Diabetes Care for People with Serious Mental Illness: Eye Exam	NCQA

NQF: National Quality Forum NCQA: National Committee on Quality Assurance AHRQ: Agency for Healthcare Research & Quality

APPENDIX C. ABBREVIATIONS/ACRONYMS

- **ACO** – Accountable Care Organization
- **APM** – Alternative Payment Model
- **CCM** – Chronic Care Management
- **CMS** – Centers for Medicare and Medicaid Services
- **DHMH** – Maryland Department of Health and Mental Hygiene
- **FFS** – Fee for Service
- **HCBS** – Home and Community-based Services
- **HH** – Health Home
- **HSCRC** – Health Services Cost Review Commission
- **ICT** – Interdisciplinary Care Team
- **I/DD** – Intellectual/Developmental Disability
- **LTSS** – Long-term Services and Supports
- **MACRA** - Medicare Reform and CHIP Reauthorization Act of 2015
- **MA D-SNP** – Medicare Advantage Dual Eligible Special Needs Plan
- **MCO** – Managed Care Organization
- **MSSP** – Medicare Shared Savings Program
- **NextGen** – Next Generation ACO Model
- **NF** – Nursing Facility
- **PACE** – Program of All-inclusive Care for the Elderly
- **PCMH** – Primary Care Medical Home
- **PCP** – Primary Care Physician
- **PMPM** – Per Member Per Month
- **P4O** – Pay for Outcome
- **RCCE** – Regional Care Coordination Entity
- **TCOC** – Total Cost of Care